REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

REVIEW OF TWO HEALTH CARE FACILITIES IN SAN DIEGO COUNTY

P-536

JUNE 1985

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Honorable Art Agnos, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 3151
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning conditions at both the San Diego County Hillcrest Mental Health Facility and the Edgemoor Geriatric Hospital that may endanger the health and safety of patients who receive treatment at these facilities.

Respectfully submitted,

THOMAS W. HAYES
Auditor General

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SUMMARY

Conditions at both the San Diego County Hillcrest Mental Health Facility (CMH) and the Edgemoor Geriatric Hospital may endanger the health and safety of patients who receive treatment at these facilities. The Department of Health Services (DHS) has identified numerous violations of state regulations in each of these facilities. While San Diego County has implemented plans of correction for some of these deficiencies, some potentially dangerous conditions still exist.

Treatment and Care of Clients

Circumstances surrounding the deaths of three mental health clients in San Diego indicate that the actions of the staff of the CMH may have contributed to these deaths. In one instance, during September 1984, a client who had previously been admitted to the CMH for threatening to commit suicide was taken into custody by the police for threatening to jump off of the San Diego Coronado Bay Bridge. The police requested that this client be admitted into the CMH because she was a danger to herself. However, CMH staff refused to admit this client because they decided she was not suicidal. The client committed suicide within hours after she left the CMH. In another instance, during January 1985, a client was admitted to the CMH on a Friday night and diagnosed as a paranoid schizophrenic. Because the psychiatric staff is decreased during weekends, this client did not receive any further treatment until Monday morning, after he had already committed a homicide. Finally, during March 1985, CMH staff failed to follow the facility's policy that requires them to check a client's vital signs when the client is admitted. As a result, the staff did not obtain vital physical information about a client who had been diagnosed as being under the influence of an undetermined amount of an unknown substance. The staff placed the client in seclusion where he died a few hours later.

Physical Plant Problems

Rooms designated for mental health clients at Edgemoor Hospital are inappropriate for these clients; certain conditions in these rooms jeopardize clients' health and safety. One patient used exposed sprinkler pipes to commit suicide by hanging, and several other patients have attempted to do the same. Recently, the San Diego County Board of Supervisors approved funding for the removal of these pipes. The removal is scheduled for completion by August 1, 1985. In addition, during September 1983, the program manager for Edgemoor requested the installation of an electronic system that would allow clients in seclusion rooms to call nurses. As of May 17, 1985, the San Diego County Department of General Services had not started installing this system.

Unlicensed Personnel

San Diego County requires individuals employed as Mental Health Inpatient Program Managers to become Licensed Clinical Social Workers within one year of employment. However, our review revealed that two of the three county employees currently working in this position have not met this requirement. The Deputy Director of the San Diego County Department of Health Services has stated that both the Chief of Adult Mental Health Services and the County Health Services Personnel Division should have ensured that the employees obtained these licenses. To prevent this situation from occurring in the future, the deputy director stated that the county will link the probation period of new employees to the date by which a license is required.

State Monitoring

During the past year, the Licensing and Certification Division of the DHS has identified several violations of state regulations, covering many aspects of the operation of a health care facility, at both Edgemoor and the CMH. As a result of these violations, the DHS has issued numerous statements of deficiencies to each facility. Although the DHS is prohibited from issuing citations to hospitals like the CMH, it did issue 18 citations to Edgemoor, requiring San Diego County to pay $13,000 in fines to the State. According to the San Diego District Administrator for the Licensing and Certification Division, San Diego County has offered plans of corrections for all of these deficiencies and has started implementing these plans.

At present, the DHS inspects psychiatric facilities like the CMH without the services of professional psychiatric staff. DHS officials have told us that their inspections would benefit greatly if a consulting psychiatrist and psychiatric nurse were available to them.

Recommendations

To give the DHS the full range of enforcement mechanisms it requires to ensure the health and safety of individuals who receive psychiatric treatment at hospitals, the Legislature should enact legislation granting the DHS the authority to issue citations and to assess penalties against hospitals.

To further ensure the safety of mental health clients who receive treatment in licensed health facilities, the DHS should acquire the consulting services of psychiatrists and psychiatric nurses for reviews of facilities that provide psychiatric care.

INTRODUCTION

Public mental health treatment programs in California are administered jointly by the Department of Mental Health (DMH), the Department of Health Services (DHS), and each of the 58 counties. The DMH directs and coordinates statewide efforts to treat and prevent mental disabilities, oversees the programs that the counties develop, and distributes state funds to counties for mental health programs. The DHS licenses and monitors health care facilities in California, including most mental health treatment facilities. The counties provide or contract to provide services directly to mental health clients.

San Diego County Hillcrest Mental Health Facility and Edgemoor Geriatric Hospital

San Diego County is the licensed operator of both the San Diego County Hillcrest Mental Health Facility (CMH) and the Edgemoor Geriatric Hospital. The CMH is a 92-bed acute psychiatric hospital that reported expenditures during fiscal year 1983-84 of approximately $6.1 million. Edgemoor is a 323-bed skilled nursing facility which reported expenditures of approximately $8.1 million during the same period. Edgemoor contains a 47-bed Special Treatment and Rehabilitation (STAR) unit for mental health clients. The care provided by these facilities is paid for primarily by Medi-Cal,

Medicare, Short-Doyle funds, State Assistance to Local Government funds, county funds, and patient fees.* Both of these facilities often function as the last resort for indigents who require either physical treatment, mental health treatment, or both.

Enforcement of State Laws and Regulations

The DHS is responsible for ensuring that health care facilities in California comply with state laws and regulations. To meet this responsibility, the Licensing and Certification Division of the DHS inspects each facility it licenses at least every two years, except for hospitals, which it inspects every three years. In addition, the DHS conducts annual surveys to determine whether facilities that apply for Medicare and Medi-Cal reimbursement meet the requirements for participation in these programs. The DHS also conducts investigations in response to complaints about a facility.

When the DHS determines that a facility is not complying with laws and regulations, it issues statements of deficiencies. The facility must then submit a plan of correction to the DHS indicating how the problems cited will be corrected. The DHS may also issue citations and thereby assess penalties against long-term health care

*Funds authorized by the Short-Doyle Act provide a continuum of support services at the community level for mental health clients. The DMH receives its Short-Doyle appropriation from the State's General Fund and then allocates these funds to the counties.

facilities for violations that affect the health and safety of patients. The DHS does not have the authority to issue citations to hospitals.

The DMH is responsible for approving the counties' individual plans for the expenditure of Short-Doyle funds for mental health services. These services include community education, 24-hour treatment and care, "day" treatment and outpatient care, and other support services. However, San Diego County is one of three counties that receive Short-Doyle funds without submitting an annual plan to the DMH. Instead, San Diego County enters into a contract with the DMH and agrees to certain minimum standards in exchange for a negotiated amount of Short-Doyle funds. Furthermore, under the terms of this arrangement, which was established by law in 1983, these three counties each conduct an internal evaluation of the mental health services they provide. The results of these evaluations are then submitted to the DMH.

Scope and Methodology

The objective of this audit was to review the efforts of the Department of Health Services and the Department of Mental Health to ensure that the CMH comply with state laws and regulations. We examined the DMH's most recent program review of San Diego County's mental health programs as well as the county's most recent self-evaluation submitted to the DMH. We also reviewed the case files

for the CMH and Edgemoor maintained by the San Diego District Office of the DHS' Licensing and Certification Division.

We visited the San Diego County Department of Health Services and interviewed the deputy directors who are responsible for the operation of the CMH and Edgemoor. We also visited each facility and interviewed the administrators. In addition, we reviewed the credentials of various supervisory personnel and interviewed both supervisors and staff who are responsible for treatment and care at these facilities. We have discussed the contents of this report with these county officials and have considered their comments in preparing the final version of the report.

We also reviewed the medical record files associated with the deaths of clients at the CMH. We questioned the Chief of the Adult Mental Health Services at the CMH about these deaths. We did not conduct a similar file review at Edgemoor because we were satisfied with the actions the DHS had already taken against Edgemoor. Finally, we reviewed financial records for the CMH and Edgemoor maintained by the San Diego County Department of Health Services.

AUDIT RESULTS

I

THE DEATHS OF THREE CLIENTS OF THE SAN DIEGO COUNTY HILLCREST MENTAL HEALTH FACILITY MAY HAVE BEEN PREVENTABLE

Our review of the circumstances surrounding the deaths of three clients of the San Diego County Hillcrest Mental Health Facility (CMH) since September 1984 indicates that these deaths may have been prevented if the CMH staff had admitted a client brought to the facility by the police, if the CMH had adequate psychiatric staffing during weekends, and if the CMH staff had followed the facility's policies. The Department of Health Services (DHS) has issued statements of deficiencies to the CMH for two of these three deaths.

A CMH Client Commits Suicide in September 1984

At 6:00 a.m. on September 9, 1984, the Coronado Police Department received a report that Client A had left her residence and was driving to the San Diego Coronado Bay Bridge in a distraught state of mind. The police located Client A shortly thereafter sitting on the railing of the San Diego Coronado Bay Bridge, threatening to jump. The police convinced Client A not to jump from the bridge, took her into custody, and transported her to the CMH at approximately 7:00 a.m.

The police considered Client A to be a danger to herself and requested that the CMH admit her for 72 hours for evaluation and treatment pursuant to Section 5150 et seq. of the Welfare and Institutions Code. However, the screening psychiatrist on duty rejected the police request, stating that Client A "is not deemed suicidal at this time." Client A left the CMH after only 42 minutes and was advised to continue seeing her private psychiatrist. There was no documentation in Client A's file indicating that CMH staff ever attempted to contact Client A's private psychiatrist about her attempted suicide. Client A returned to the San Diego Coronado Bay Bridge and committed suicide approximately 12 hours after she left the CMH.

Both the Coronado police and the CMH were familiar with Client A from her previous attempts to commit suicide. During a similar episode six months earlier, in March 1984, Client A was brought by the Coronado police to the CMH where she was examined by a screening psychiatrist who reported, "Client A is in early psychotic decompensation, and with impaired judgment/insight is definitely a grave danger to her own safety and very nearly killed herself an hour ago." The screening psychiatrist then transferred Client A to Mesa Vista Hospital. In August 1984, just three weeks before she committed suicide, Client A was admitted into the CMH for threatening to commit suicide.

Despite the fact that Client A had previously been admitted to the CMH because she was deemed to be a danger to herself and that the police who apprehended her on September 9, 1984, believed that she was once again a danger to herself, the Chief of Adult Mental Health Services at the CMH supports the screening psychiatrist's decision not to admit Client A. The chief stated that "[the screening psychiatrist] is a board-certified psychiatrist. If she felt that [Client A] was not suicidal when she examined her on September 9, 1984, then she was not suicidal." He further asserted that "people say they are going to kill themselves all the time; if someone really wants to kill themself, there isn't much that we can do about it."

A Client Commits a Homicide
at the CMH in January 1985

During the early evening of Friday, January 11, 1985, the San Diego police brought Client B to Alvarado Hospital because he was behaving strangely. Client B was given a sedative at Alvarado Hospital and was transferred to the CMH by the police at the request of the hospital staff. The screening psychiatrist at the CMH examined Client B at about 9:00 p.m. on January 11, 1985, diagnosed him as a paranoid schizophrenic, and admitted him into the CMH for "chemotherapy and further diagnosis." The screening psychiatrist wrote two prescriptions for Client B, both to be administered on an "as needed" basis at the discretion of the nursing staff. The psychiatrist also ordered the staff to place Client B on suicide precaution watch.

Sometime between 4:00 a.m. and 6:00 a.m. Monday, January 14, 1985, Client B was given a sedative and placed in a seclusion room by the nursing staff because he had been wandering around the ward during the entire night shift. According to his medical records, this injection was the first dose of medication that Client B had received after his transfer from Alvarado Hospital. Despite the fact that medical records indicate that the nursing staff reported that Client B was depressed throughout his weekend stay at the CMH, Client B was neither given any medication nor seen by a psychiatrist for approximately 56 hours after his admission into the facility.

Sometime early Monday morning, before he was given a sedative, Client B committed a homicide, killing a mental health client who had been admitted into the CMH approximately one month earlier. Consequently, Client B was released by the CMH to the San Diego Police Department at 11:00 a.m. on Monday, January 14, 1985.

Title 22, Section 71205(b)(2) of the California Administrative Code requires acute psychiatric hospitals to have "sufficient psychiatrists on staff to meet the needs of clients." The Chief of Adult Mental Health Services at the CMH has told us that there is a need for additional psychiatric coverage at the CMH during weekends. Because there are fewer psychiatrists on staff on weekends, it is not unusual for a client to be admitted by a screening psychiatrist on a Friday evening and not be seen again by a psychiatrist until Monday

morning. He further stated that if Client B had been admitted on a weekday night, he would have been seen by a psychiatrist the following morning, and the psychiatrist might have provided additional treatment.

The Chief of Adult Mental Health Services told us that the CMH has made several efforts to hire additional psychiatrists. To verify his statement, we reviewed requisitions for services that the CMH submitted to San Diego County's Department of Health Services. Our review indicates that ads have been placed in various publications several times since February 1985; however, for eight months before the homicide committed by Client B, the CMH made no attempts to increase the size of the psychiatric staff.

A CMH Client Dies From Drug Overdose in March 1985

On March 3, 1985, at 1:00 a.m., Client C was brought to the CMH by the National City Police Department. Client C was diagnosed by the screening psychiatrist as being intoxicated with an unspecified substance. Client C was admitted into the CMH, and because he was agitated, he was placed in a seclusion room and restrained in bed at 2:00 a.m. At approximately 7:30 a.m. the next morning, Client C was pronounced dead. The cause of death was the overdose of methamphetamine that Client C had taken before he was brought to the CMH.

Procedures established by the San Diego County Department of Health Services require the CMH staff to check a patient's vital signs by the time a client is admitted onto a ward. If a client cannot be controlled during the admission process, then the staff must check the client's vital signs as soon as the client's behavior will allow such tests to be conducted. At the time of his admission, Client C was agitated; therefore, his vital signs could not be checked. However, medical records indicate that by 2:30 a.m., Client C was resting quietly; the CMH staff could have taken his vital signs at that time.

The Chief of Adult Mental Health Services at the CMH has stated that the CMH staff failed to follow the hospital's procedures in this case. He further stated that it was the shared responsibility of the screening psychiatrist who examined Client C and the nursing staff to ensure that Client C's vital signs were checked as soon as possible after he was admitted into the hospital. Another member of the psychiatric staff has stated that if Client C's vital signs had been checked, they may have indicated a need for additional treatment that could have prevented Client C's death.

County Actions Taken by the DHS and San Diego County in Response to Patient Deaths

The DHS has issued statements of deficiencies to the CMH in two of the preceding cases. In the case of Client B, the DHS issued deficiencies to the CMH for failing to implement suicide precautions,

failing to have a daily psychiatric evaluation of the patient, and failing to document nighttime checks on this patient. In the case of Client C, the DHS issued deficiencies to the CMH for failing to check the client's vital signs and for failing to follow regulations concerning the use of physical restraints. The hospital's administration responded to these statements of deficiencies by developing plans of correction that include retraining for some staff and improvements in recordkeeping.

Since the completion of our fieldwork in May 1985, San Diego County officials have stated that they intend to take several additional corrective actions. The Director of the San Diego County Department of Health Services has stated that six case files, including those maintained for Client A and Client C, have been sent to the San Diego Psychiatric Society's Peer Review Committee. The director further stated that this committee's decision on whether these clients were cared for appropriately will determine the need for further disciplinary action at the CMH. In addition, the Deputy Director for Mental Health has stated that the Chief of Adult Mental Health Services has been relieved of his responsibilities at the Hillcrest Mental Health Facility. These responsibilities have been assumed temporarily by the San Diego County Department of Health Services' Clinical Director for Mental Health Services. The deputy director explained this action by stating that "County Mental Health feels that CMH Hillcrest needs a Medical Director and a Hospital Administrator whose sole area of responsibility is directing the mental health programs at

CMH Hillcrest." The Chief of Adult Mental Health Services had been responsible for other county programs in addition to the CMH. Finally, the Deputy Director for Mental Health has stated that Short-Doyle funds will be used to hire additional staff for the CMH, including the equivalent of 2.92 staff psychiatrists, as soon as possible.

The California Health and Safety Code grants the DHS the authority to issue citations and thereby levy fines against long-term health care facilities in response to violations that could harm the health, safety, or security of patients. However, state law does not authorize the DHS to issue citations when hospitals commit similar violations. We have previously discussed the need for this additional enforcement option in our March 1985 report titled, "The State's Mental Health System Could Be Operated More Cost-Effectively and Could Better Meet the Needs of Clients" (Report P-441, March 1985, Chapter III).

II

PHYSICAL PLANT PROBLEMS AT EDGEMOOR GERIATRIC HOSPITAL COULD ENDANGER CLIENTS

Rooms used by mental health clients admitted to the Special Treatment and Rehabilitation (STAR) unit at Edgemoor Geriatric Hospital are inappropriate for these clients and could endanger their health and safety. San Diego County plans to correct these problems; however, in two cases corrective action has not yet been implemented.

Exposed Sprinkler Pipes in Clients' Rooms

During our inspection of Edgemoor on April 24, 1985, we observed exposed sprinkler pipes suspended from the ceilings of clients' rooms in the STAR unit. Our review of the DHS' files indicates that a client committed suicide by hanging from these pipes in February 1984. In addition, in an interview with the program manager of the STAR unit, we learned that there have also been several unsuccessful attempts at suicide involving these same sprinkler pipes.

On May 14, 1985, the San Diego County Board of Supervisors approved funding to eliminate the dangerous situation created by these sprinkler pipes. The Director of the San Diego County Department of General Services has told us that this project will be completed by August 1, 1985.

Facility Improvements Requested for Edgemoor Have Not Been Made Promptly

When the administrators of Edgemoor identify a need for significant maintenance work at the facility, they must submit a work request to the San Diego County Department of General Services. The director of this department has stated that such requests must then compete with all other county maintenance needs.

Our review disclosed that, in the past, work requests that could affect the health and safety of individuals who receive care at Edgemoor have not been acted on promptly. For example, during September 1983, the program manager of the STAR unit requested the installation of an electronic system that would allow clients in seclusion rooms to call nurses. This request was resubmitted to the county's Department of General Services during April 1985. According to the Director of the San Diego County Department of General Services, the system has not yet been installed because of misunderstandings between the county's departments of General Services and Health Services concerning the requirements of this project. Consequently, as of May 17, 1985, the San Diego County Department of General Services had not started installing this system.

Another example concerns a request for a lock on a door to prevent clients from walking through the room in the STAR unit where medications are kept. The program manager of the STAR unit requested this work during September 1984. The lock was finally installed by the Department of General Services six months later, in March 1985.

The DHS issued numerous statements of deficiencies to Edgemoor during March 1985 for general maintenance problems. As part of its plan to correct these deficiencies, the administrator of Edgemoor has indicated that the county's Department of General Services will devote additional resources to meeting Edgemoor's needs, including the assignment of supplemental maintenance staff to Edgemoor on a full-time basis.

III

TWO COUNTY PROGRAM MANAGERS HAVE NOT MET LICENSURE REQUIREMENTS

San Diego County requires individuals hired as Mental Health Inpatient Program Managers (MHIPM) to become licensed within one year of the date they are hired. During 1985, two of San Diego County's three MHIPM's failed to meet this requirement. The county intends to take corrective action to prevent this from recurring.

The job description issued by San Diego County for the MHIPM position indicates that applicants must either be licensed or be "license-eligible" and obtain a license within one year of the date they are hired. During 1985, two of the county's three MHIPM's failed to meet this requirement. One of these MHIPM's has stated that he will take the examination this year and thereby attempt to meet the licensure requirement. However, according to the Deputy Director for Mental Health of the San Diego County Department of Health Services, another MHIPM did not take the licensure examination at the time she proposed to do so in April 1984 and has recently been dismissed by the county.

The Deputy Director for Mental Health of the San Diego County Department of Health Services has stated that the Chief of Adult Mental Health Services and the County Health Services Personnel Office are responsible for ensuring that MHIPM's receive their licenses. The

deputy director further stated that a new system will be implemented to prevent this problem from recurring. This system will link a new employee's probation period to the date by which licensure is required.

IV

THE DEPARTMENT OF HEALTH SERVICES HAS IDENTIFIED NUMEROUS VIOLATIONS AT EDGEMOOR GERIATRIC HOSPITAL AND THE SAN DIEGO COUNTY HILLCREST MENTAL HEALTH FACILITY

The Department of Health Services' (DHS) Licensing and Certification Division has issued numerous statements of deficiencies to both Edgemoor Geriatric Hospital and the San Diego County Hillcrest Mental Health Facility (CMH) since May 1984; at Edgemoor, the DHS has issued 18 citations. The CMH has not received any citations because the DHS cannot issue fines to hospitals. The violations of state regulations that the DHS has identified in these facilities cover many different aspects of the operation of a health care facility. According to the San Diego District Administrator of the DHS' Licensing and Certification Division, San Diego County has offered plans of correction for all of these deficiencies and has started implementing these plans.

Since May 1984, the DHS' inspectors have visited Edgemoor on 11 separate occasions for full-scale surveys, follow-ups to surveys, and investigations of complaints. During these visits, the DHS has issued statements of deficiencies pertaining to administrative policies and procedures, personnel policies and procedures, patients' rights, patient care, size of staff, rehabilitative services, administration of medications, storage of drugs, food service, sanitary conditions, medical records, patients' rights, general maintenance, and patient

discharge planning. Moreover, since May 1984, the DHS has issued 18 citations to Edgemoor requiring San Diego County to pay $13,000 in fines to the State. San Diego County has developed plans of correction for all the deficiencies the DHS has identified at Edgemoor and has started implementing these plans. As part of its effort to improve conditions at Edgemoor, San Diego County plans to increase the staff at Edgemoor by 56.5 positions.

The DHS inspectors have conducted two recent licensing surveys at the CMH: one in November 1984 and another in May 1985. As of June 7, 1985, the DHS has not yet reported on its May survey, but during its November 1984 survey, the DHS issued statements of deficiencies pertaining to patient records, patient treatment, size of staff, supervision of staff, therapeutic activities, patients' rights, and general maintenance. These statements of deficiencies were issued in addition to those mentioned earlier in regard to the client deaths. The CMH has not received any citations for these violations because the DHS cannot issue citations to hospitals. As it has done at Edgemoor, San Diego County has developed plans of correction for all the deficiencies the DHS has identified at CMH and has started implementing these plans.

Currently, the DHS inspection teams complete detailed reviews of facilities that provide psychiatric services, like those at Edgemoor and the CMH, without the expertise of psychiatric staff. Both the Deputy Director and the San Diego District Administrator of the DHS'

Licensing and Certification Division have stated that inspections of facilities like the CMH would benefit greatly from the services of a consulting psychiatrist and psychiatric nurse. At present, such expertise is not available within the DHS.

V

CONCLUSION AND RECOMMENDATIONS

Conditions at both the San Diego County Hillcrest Mental Health Facility and the Edgemoor Geriatric Hospital may endanger the health and safety of individuals who receive treatment at these facilities. Circumstances surrounding the deaths of three clients of the CMH indicate that these deaths may have been preventable. In addition, rooms used by clients admitted to the Special Treatment and Rehabilitation unit at Edgemoor are inappropriate for their needs. Other physical plant problems at Edgemoor have not received prompt attention from the county's Department of General Services. Furthermore, two Mental Health Inpatient Program Managers, one at each facility, failed to meet county licensure requirements. The Department of Health Services has issued numerous statements of deficiencies to both facilities as well as 18 citations to Edgemoor since May 1984. According to the San Diego District Administrator of the DHS' Licensing and Certification Division, San Diego County has developed plans of correction for all the deficiencies identified by the DHS and has started to implement these plans.

Recommendations

The DHS lacks the full range of enforcement mechanisms it needs to ensure the health and safety of individuals who receive

psychiatric treatment at hospitals; therefore, the Legislature should enact legislation that would grant to the Department of Health Services the authority to issue citations and to assess penalties against hospitals.

To ensure the health and safety of individuals who receive mental health treatment at any licensed health facility in California, the Department of Health Services should acquire the consulting services of psychiatrists and psychiatric nurses for reviews of facilities that provide psychiatric care. These consultants may be provided by the Department of Mental Health or independent sources, depending upon how often such expertise is needed.

To ensure the health and safety of individuals who receive treatment at Edgemoor Geriatric Hospital and the San Diego County Hillcrest Mental Health Facility, the following should be done:

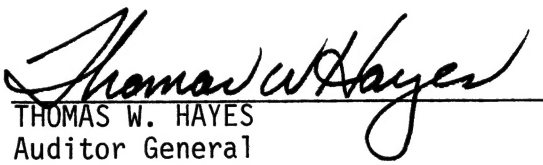
- The Department of Health Services and the Department of Mental Health should ensure that the CMH maintains an adequate level of psychiatric staff seven days a week.

- The Department of Health Services should ensure that all maintenance work that affects the health and safety of clients is completed promptly at Edgemoor.

- The Department of Mental Health should ensure that San Diego County enforces licensure requirements for all county mental health positions that require licensed personnel.

We conducted this review under the authority vested in the Auditor General by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



THOMAS W. HAYES
Auditor General

Date: June 24, 1985

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cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF HEALTH SERVICES
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June 21, 1985

Mr. Thomas Hayes
Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

The following comments are submitted in response to recommendations made in your draft report entitled, "Review of Two Health Care Facilities in San Diego County". The comments which follow have been coordinated with staff of the Department of Mental Health.

Recommendation: The Legislature should enact legislation that would grant the Department the authority to issue citations and assess penalties against hospitals.

DHS Comment: The Department feels that the citation process is an effective enforcement tool and fully supports the concept of legislation that would enable the Department to issue citations and assess penalties against hospitals.

Recommendation: The Department of Health Services should acquire the consulting services of psychiatrists and psychiatric nurses for reviews of facilities that provide psychiatric care.

DHS Comment: The Department feels that the availability of psychiatrists and psychiatric nurses for review of psychiatric facilities is highly desirable. DHS has already utilized psychiatrists, psychologists and psychiatric nurses from DMH in a coordinated team approach in resolving problems in psychiatric facilities in the San Diego area as well as other parts of the State. It is our position that this collaborative effort will meet the intent of the recommendation without the need to employ additional consultive staff.

Recommendation: The DHS and DMH should ensure that the CMH maintain an adequate level of psychiatric staff seven days a week.

DHS Comment: The San Diego District Office of the Licensing & Certification Division will monitor the level of psychiatric staffing of the CMH periodically to ensure that San Diego County is carrying out their plan of correction.

DMH Comment: Current professional staffing ratio at Hillcrest exceeds the requirements of Title 9, however, weekend coverage did reveal problems in staff utilization.

Recommendation: The DHS should ensure that all maintenance work that affects the health and safety of clients is completed promptly at Edgemoor.

DHS Comment: The San Diego District Office of the Licensing and Certification Division will continue to monitor the progress of all maintenance work at Edgemoor to ensure its prompt completion.

Recommendation: The DMH should ensure that San Diego County enforces licensure requirements for all county mental health positions that require licensed personnel.

DMH Comment: The issue of unlicensed personnel functioning in positions which, according to county policy, call for licensed staff, is an administrative problem and not a violation of any regulation or law. (1)

Sincerely,

Kenneth W. Kizer, M.D., M.P.H.
Director

cc: D. Michael O'Connor, M.D.
Director
Department of Mental Health

David B. Swoap, Secretary
Health and Welfare Agency

Auditor General Comment:

(1) We only intended that the DMH enforce requirements that county personnel be licensed when state law requires licensure.